ATTACHMENT 13

Sample ADA 2000 claim form for HealthCheck nursing agencies billing for dental sealants

Dental Claim Form

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1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services — Specialty (see backside)
2. ☐ Medicaid Claim ☒ EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle): Recipient, Im A.
9. Address
10. City
11. State
12. Date of Birth (MM/DD/YYYY): MM/ DD / YYYY
13. Patient ID #: 1234567890
14. Sex: ☐M ☐F
15. Phone Number ( )
16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN#
20. Employer Name
21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address
24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / /
29. Marital Status: ☐Married ☐Single ☐Other
30. Sex: ☐M ☐F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan: ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical
32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / /
35. Sex: ☐M ☐F
36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status: ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity: I.M. Provider
43. Phone Number ( )
44. Provider ID #: 12345678
45. Dentist Soc. Sec. or T.I.N.
46. Address: 1 W. Williams St.
47. Dentist License #
48. First visit date of current series:
49. Place of treatment: ☒Office ☐Hosp. ☐ECF ☐Other 71
50. City: Anytown | 51. State: WI | 52. Zip Code: 55555
53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No
54. Is treatment for orthodontics? ☐Yes ☒No
If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: _____ Date of prior placement: _____
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes — Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither — Brief description and dates

58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
MM DD YYYY	02			D1351	1	Sealants	XX.XX
MM DD YYYY	03			D1351	1	Sealants	XX.XX
MM DD YYYY	18			D1351	1	Sealants	XX.XX
MM DD YYYY	19			D1351	1	Sealants	XX.XX

Admin. Use Only

60. Identify all missing teeth with "X"

Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	XX.XX
Payment by other plan	XX.XX
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X I.M. Provider 87654321 MM/DD/YYYY
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

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J588 (Same as ADA Dental Claim Form) – J589, J590, J591

To Reorder, call 1-800-947-4746